

Building a Patient-Centered Medical-Legal Home in Hawai'i's Kalihi Valley

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Abstract

The Medical-Legal Partnership for Children in Hawai'i (MLPC) has worked to address the social determinants of health for low-income patient-families since 2009. Focused on identifying health-harming legal needs, doctors and lawyers work together to assist families with family law, housing, public benefits, education, employment, civil rights, and other concerns. Providing free, direct legal service in the medical setting allows the medical-legal partnership (MLP) team to identify community-wide concerns such as language access violations, racial discrimination, and unfair policies. These individual concerns then inform systemic advocacy and community engagement efforts. The MLPC Hawai'i team has grown through its experiences working with public housing residents, Micronesian migrant communities, and low-income families, ultimately evolving the national MLP framework to become a patient-centered "medical-legal home." This evolution is possible through the utilization of "rebellious lawyering" concepts of working with, not just on behalf of, community clients. This article will introduce the concept of a medical-legal partnership, provide examples of lessons learned from working alongside vulnerable and resilient communities, and explore the idea of the patient-centered medical-legal home as an innovative program to improve the social determinants of health and reduce health disparities.

Keywords

Medical-Legal Partnerships, Micronesia, Compact of Free Association, medical-legal home

Abbreviations and Acronyms

CHC = community health center

COFA = Compact of Free Association

COFACAN = COFA Community Advocacy Network (COFACAN).

KKV = Kokua Kalihi Valley Comprehensive Family Services

MLP = medical-legal partnership

MLPC = Medical-Legal Partnership for Children in Hawai'i

PCMH = patient-centered medical home

Highlights

- "Legal care" can remedy medical problems rooted in legal problems.
- Doctors and lawyers can partner to improve the health and well-being of patients.
- Hawai'i has had a Medical-Legal Partnership since 2009.
- "Medical-Legal Homes" must ultimately focus on patient power and autonomy.

Introduction

To introduce the concept of a medical-legal partnership (MLP), consider a common clinic example of a child with asthma who also has a housing issue:

A 7-year-old Micronesian boy walks into his pediatric clinic with coughing and wheezing. This is his third visit this year for an asthma exacerbation and he is prescribed yet another round of oral steroids despite being on a good controller regimen. The asthma takes its toll on his health, and each exacerbation

negatively impacts his family's well-being as he misses more school and his parents miss work.

Frustrated by the lack of improvement, the pediatrician asks a few questions about environmental triggers and discovers that the patient's asthma is actually a housing problem: There is a leaky pipe causing moldy walls in the child's bedroom. The parents share that they have reported the problems to their landlord for nearly 2 years, all to no avail.

This is a health-harming legal need.¹ Recognizing this, the time-constrained pediatrician, who has no legal training, could consider writing a letter to the landlord, though in our experience, it would likely be ignored. A lawyer would be able to address this legal need, but this family would likely be unable or unwilling to seek an attorney due to significant barriers such as the cost of private attorneys, the lack of knowledge about available free legal services, the fear of contacting a lawyer, or the lack of the necessary time, transportation, or language skills required to navigate legal services. The MLP legal team, on-site and integrated into the medical practice, can overcome both the medical and legal barriers to addressing this problem as returning to our clinical example will show:

Building on the trust the doctor has established with the patient but also armed with relevant legal language and a "JD" attached to her name, the MLP attorney meets the family during the child's medical visit and subsequently persuades the landlord to repair the pipe and clean up the mold. The apartment is fixed 1 week after the MLP lawyer intervenes. This brief legal intervention results in better health for the child by removing the primary trigger for his asthma. Subsequently, he requires fewer medical visits and no further hospitalizations. He has improved educational stability, more self-esteem, and more friends at school. By reducing missed work days, the parents stabilize their income and improve their economic, housing, and food security. His health-harming legal need is resolved.

In addition to the benefits to the child and family in this example case, consider that there may be societal benefits as well from addressing a child's health-harming legal need. For example, there may be reduced strains on safety-net hospitals due to decreases in emergency room and hospital visits. While to date, no MLP study has measured the return on investments from a societal perspective, several studies have explored the financial impacts to MLP providers (clinics and hospitals) as well as to patient-clients and have found significant return on the original investments in the MLP:

Several studies reference significant return on the investment in a medical-legal partnership model. Rodabaugh and colleagues (2010) found that an MLP targeting the needs of cancer patients generated nearly \$1 million by resolving previously denied benefit claims. Similarly, a rural MLP in Illinois was able to demonstrate a 319 percent return on the original investment of \$116,250 between 2007 - 2009. A 2008 white paper by Knight and colleagues highlighted four MLP programs, each of which demonstrated successful leveraging of health care recovery dollars (reimbursed funds to clinical settings as a result of improperly denied Medicaid or Social Security Disability claims) as a result of their program.²

Returning to our example child, he was fortunate to be seen at a pediatric “medical-legal home.” This concept builds upon the ideas of the traditional medical home. First developed by Hawai‘i pediatrician Calvin Sia, MD, in the 1980s, the patient-centered medical home approach focuses on the relationship between the provider and patient, and treats patients/families as partners in decision-making for both medical and other family resources.^{3,4} It utilizes a team approach that maintains the family at the center and driving the decisions, while the pediatrician assists in coordinating referrals to outside specialists and community partners. This approach has become widely used in health care, and in the pay-for-value movement it is often used as a measure of high-quality care. For example, the National Committee for Quality Assurance (NCQA) offers a medical home recognition program and such certification is often necessary to receive quality incentive payouts or enhanced reimbursements from insurance companies and many state and federal programs.⁵

Our approach goes one step further than the traditional medical home and co-locates and integrates a lawyer into this family-led team. In this article, we will explore how our medical home evolved to become a medical-legal home.

What Is MLPC Hawai‘i?

In 2009, Medical-Legal Partnership for Children in Hawai‘i (MLPC) was established as a collaboration between the William S. Richardson School of Law (University of Hawai‘i at Mānoa) and Kōkua Kalihi Valley Comprehensive Family Services (KKV), a federally qualified community health center, to address the social determinants of health—the social, legal, and environmental problems behind health problems. Following the MLP national framework, MLPC Hawai‘i engages in 3 core activities: (1) direct legal services on-site in a health care setting; (2) provider education about health-harming legal needs; and (3) policy and systemic advocacy work.^{1,6,7}

Each year, MLPC Hawai‘i receives about 130 requests for legal assistance from KKV health care providers and community referrals. MLPC opens about 100 legal cases ranging from brief services to full representation, and the rest receive counsel and advice, general legal information, or referrals to other legal and non-legal resources. In addition to family law and public benefits concerns, MLPC resolves dozens of housing matters. Legal staff prevent evictions, win rent adjustments and mon-

etary recoveries, and train numerous public housing residents about their legal rights. MLPC also provides regular “curbside consultations” to KKV providers and staff. Some consults lead to formal referrals to MLPC, and most strengthen the health providers’ ability to advocate for their patients without further legal assistance from the attorney. MLPC conducts quarterly workshops for KKV primary care providers, psychologists, social workers, case managers, nurses, and other outreach staff on various legal topics, focusing on the common health-harming legal needs of KKV’s patients and community populations. Additionally, MLPC provides valuable inter-professional education to students from various University of Hawai‘i programs such as pediatric residents, medical students, public health students, law students, and law fellows.

Health-Harming Legal Needs in Kalihi Valley’s Micronesian Population

Over the last 10 years, nearly 80% of MLPC clients have been migrants living in the United States under the Compact of Free Association (COFA) from the Federated States of Micronesia, mostly from Chuuk State. This reflects KKV’s Micronesian patient population, which grew from 5.4% in 2004 to over 30% in 2016. Like many immigrant groups arriving in Kalihi Valley before them, Micronesians are resilient, but they are also uniquely vulnerable.

Micronesians in Hawai‘i face numerous institutional and social barriers that significantly increase their likelihood of facing health-harming legal needs.⁸ Indeed, they face discrimination in healthcare, housing, education, social encounters, and in their representation in media images.⁹⁻¹⁷ Families also suffer from the impact of government discrimination by being systemically denied Medicaid and other essential benefits despite paying state and federal taxes and serving in the US military.^{18,19} Additionally, data show there is only one civil legal aid attorney for every 4402 low-income families in Hawai‘i, compared to one private attorney for every 361 residents in Hawai‘i, a 12-fold increase in access to justice if one can pay.²⁰

Traditional legal services for the poor in Hawai‘i have not served Micronesian people well. Until 2007, residents from COFA nations were deemed ineligible for federally-funded legal aid services including the Legal Aid Society of Hawai‘i, the state’s largest legal aid program.^{21,22} Even with access to these services, over two-thirds of Hawai‘i residents who seek legal help are turned away by legal service providers for various reasons (eg, eligibility criteria, legal conflicts of interest, lack of available resources).²⁰ Immigrants frequently face additional obstacles of language access, knowledge of available legal resources, and the inconveniences of accessing services. Members of the judicial system have also demonstrated unfairness towards Micronesians, as when a Hawai‘i prosecutor sought to “send a message to the Micronesian community” by demanding a harsh criminal sentence.^{23,24} These factors increase mistrust in the entire legal system, demanding new approaches to legal interventions for Micronesian communities. MLP is one such innovative approach.

MLP for the Micronesian Community

MLPC Hawai'i delivers much needed legal services to the Micronesian community. Most of the MLPC clients at KKV are Chuukese families living in unstable housing (public housing, doubled up, overpriced rentals) in Kalihi, a suburb of Honolulu, Hawai'i. Alongside the success of individual legal cases, the MLPC team has recognized that additional approaches to legal interventions are needed to best serve this community.

First, from our 10 years of working together, we have learned that MLP works best when the lawyer is fully integrated into the medical team.^{1,26} We focus on the critical transaction between the healthcare provider, patient/family, and the "legal care" provider. In less integrated practices, the transaction between doctor and lawyer might be done by a faxed referral, notice in the medical record, or by providing the family the phone number of the legal team member. Other practices might have a lawyer sitting in the waiting room with the expectation that a family would know they had a legal need and be able to overcome any fear or language barriers to approach the attorney. These "cold" referral systems do not work well for most vulnerable, immigrant community members. MLPC Hawai'i has been recognized as a fully integrated MLP model, engaging in a highly relational intervention that starts with a "warm" hand-off to an on-site attorney in which the physician introduces the lawyer to the patient as soon as a legal need is identified, initially meeting together in the exam room with a trained interpreter.^{25,27}

This transaction is critical in working with Micronesian communities as it builds upon the pre-existing trust between the patient and the health care provider and reduces the intimidation of speaking with lawyers. It also removes barriers of inadequate language access, inadequate legal knowledge, and lack of access to a working phone and transportation, by creating a one-stop approach to medical and legal services. MLPC Hawai'i attempts to address the patient's need in the moment it is identified rather than postponing it for another appointment. This can be vital for clients unable to miss additional work days and often is critical for domestic violence victims whose concerns may be unsafe to postpone or for whom it may be unsafe to ask to return another day. Furthermore, too often immigrant families have lost faith from dealing with the various systems around them or even fear repercussions for seeking help. They are often incredulous that there is someone who wants to help them. The immediate warm hand-off breaks down these common yet unseen barriers to accessing legal services.

Second, we look to public health research showing that Micronesian communities respond best to interventions that are highly relational and community-centered, and that foster community empowerment.²⁸ For example, a Pacific Diabetes Today project adopted "culturally appropriate strategies...to gain access to the community, transfer knowledge and skills, build coalitions, and provide technical assistance" with a goal of Micronesian community empowerment.²⁹ As illustrated next, this resonates with the MLPC lawyering approach that honors community power, knowledge, and self-advocacy skills.

Integrated legal services, warm hand-offs, and public health foundations represent MLP best practice, but more can be accomplished. The third and most critical lesson is that the relationship between the family and the legal care provider must evolve to meet the unique needs of Micronesian (and all) community members. Indeed, the national MLP framework has yet to fully embrace the critical role of the patient-client as an essential member of the medical-legal partnership team, and not a mere subject of the medical-legal intervention. Not embracing the patient-client as part of the team risks systemic advocacy being driven without the vision, voice, and action of the community. At MLPC Hawai'i, we draw on community lawyering techniques (developed from "rebellious lawyering" described later) to create a medical-legal home for patient-families at KKV. In our MLP approach, the family is a central and equal partner in legal problem-solving and decision-making, and the community drives policy and advocacy efforts. Three composite examples illustrate MLPC's unique medical-legal home approach with Micronesian communities in Kalihi Valley.

Adapting the MLP Framework Alongside the Micronesian Population: Case Studies From Crisis Lawyer to Family Lawyer

Six months after resolving the leaky pipe and moldy walls, the parents walk into KKV without a medical appointment and ask to see the lawyer again. The father works 50 hours per week at a restaurant in Waikiki but does not receive health insurance or overtime wages. His manager is pressuring him to sign a paper declining health coverage. After discussing his employment rights, including retaliation protections, the MLPC attorney offers to call his employer or to help him file a complaint with the Department of Labor. The father hesitates, saying he will try to resolve the problem on his own. The lawyer then suggests that the father try the magic words, "I need to talk to my lawyer first." After laughing at the notion of having his own lawyer—something only rich people have in the movies—he agrees to try this. Two weeks later, he proudly reports that he now has health insurance and overtime pay, and so do all the other kitchen workers. He has learned valuable self-advocacy skills and he now sees MLPC as his "family lawyer."

What started as a typical MLP referral for legal care has grown into a client-lawyer relationship that resembles a medical-legal home. The client has moved past his early legal emergencies and now engages the MLPC attorneys as he would a medical home provider—for legal check-ups and to ask questions about potential problems before they become crises. Like many MLPC Hawai'i clients, this father has learned the legal tools to resolve his own problems, and he shares them with other members of his family and community. Furthermore, the legal staff has in turn learned from the client about how laws—in this case employment protections and Hawai'i's health care laws—play out in the real world. The lawyers must adjust their advice and solutions in accordance with their clients' wishes or they risk losing their trust and partnership. This is no different

than a patient-centered medical home (PCMH) provider being aware that a \$5 or \$10 co-pay could make a prescription out of reach for a family in poverty. In a patient-centered medical-legal home, like in a PCMH, the patient is an equal partner in determining the treatment plan. Listening and responding to the stories of patients and clients can mean the difference between health or sickness, employment sufficient to pay for housing or homelessness for individuals and families.

Self-Advocacy and Client Empowerment

In 2015, MLPC Hawai'i created an "Advocacy Academy" with the mostly Chuukese women participants of KKV's Seams Wonderful Sewing Program. Advocacy Academy is a series of monthly workshops to educate participants about their basic legal rights in areas of family law, housing, public benefits, and other self-directed topics. The women learn tangible skills through small group activities. Participants practice note-taking skills and role-play various scenarios including asking for an interpreter and requesting documentation. MLPC staff describe Advocacy Academy as "mini law school." Indeed, this project focuses on community empowerment and augments the remarkable self-advocacy already being done by these Chuukese women.

Advocacy Academy participants also learn policy matters so that they understand not only what is happening, but why. The result has been their ability to affect immediate change: They can identify situations in which they can advocate to have an interpreter present, know when to use the phrase, "My lawyer said..." and can better navigate complex systems (housing, benefits, healthcare, courts, etc). Significantly, this work reaches beyond the individual participants. A preliminary evaluation of 10 Advocacy Academy participants found that they had shared their knowledge with dozens more family members, neighbors, and church friends. One Chuukese woman said, "After every class, I go home and share what I learned with my children." Participants told stories of successful self-advocacy in housing, healthcare, and other areas.

As noted earlier, this work closely parallels the public health strategies employed by diabetes educators in Pacific Island communities. With similar goals of community empowerment and engagement, the MLPC Advocacy Academy approach mirrors the culturally-appropriate strategies and outcomes of developing knowledge through collaborative learning, supported by the medical-legal team.²⁹ The result is better individual and population health by stabilizing housing, employment, education, and healthcare.

Community-led Policy and Civic Engagement

During an Advocacy Academy session, several Chuukese participants shared stories about problems with their "Obamacare" health insurance.³⁰ One woman said, "I don't want to use my insurance because they sent me bills before I even saw a doctor." A common message was, "Our community is confused after being switched from MedQuest (Medicaid) to Basic Health Hawai'i (state-funded limited health plan), and now to Obamacare." MLPC staff invited the participants to

join Micronesia-led policy activities organized by the ad hoc group COFA Community Advocacy Network (COFACAN), where they were able to talk about their community's concerns and then share their knowledge with others in the community.

Supporting COFACAN is an example of how MLP has engaged in community-led policy and civic engagement. Since 2009, when the state of Hawai'i began denying COFA residents access to state-funded Medicaid benefits, MLPC Hawai'i has worked with Micronesia community leaders, medical and legal professionals, Med-QUEST (Hawai'i's Medicaid program) patients, students, allies, and policymakers, to address health justice for Micronesians in Hawai'i through educational efforts, community organizing, and supporting community-directed advocacy.^{8,19,27} In 2012, MLPC Hawai'i co-founded COFACAN to support community-led efforts to press for state and federal health policy changes. COFACAN activities have kept discussions about Micronesia health issues alive in local communities as well as in state and federal policy groups.³⁰⁻³²

These activities demonstrate how a team of medical and legal professionals can work together, side-by-side with their patient-client communities, to engage in systemic advocacy and policy solutions that emerge from the ground up. For MLPC, success is not measured solely by objective policy change but rather by community change. For example, the group considers whether more Micronesia patients are becoming active advocates, pressing for improvements in their own lived circumstances and communities, and whether MLPC clients are gaining the legal and health knowledge needed to navigate systems and to challenge agency and governmental policies that affect access to necessary benefits. Vehicles like COFACAN and Advocacy Academy provide avenues for civil engagement and community power.

These case examples illustrate the lessons learned from MLPC's collaboration with COFA families in Kalihi. The 3 lessons—namely, (1) the significance of relationships, as seen in becoming the community's "family lawyer"; (2) the importance of working with and not just on behalf of the community; and (3) the goal of empowering the community to become the advocates themselves—are the foundation of the new MLPC Hawai'i framework. These 3 lessons have guided the evolution of the model into its natural next phase, the medical-legal home.

A "Rebellious" Approach to MLP: The Medical-Legal Home

Contrary to its combative-sounding moniker, the concept of "rebellious lawyering" embodies the collaborative and community (patient)-centered principles evident in the PCMH model.^{3,4} Rebellious lawyering challenges the formal, top-down approach to law that permeates legal education and professionalism, including legal aid services in the United States.³³⁻³⁵ It embraces working with, not just on behalf of, marginalized people. But rebellious lawyering also requires working against subordination, and challenging practices and narratives that maintain inequality. A rebellious approach seeks empowerment for clients as self-advocates and for communities as active agents

of systemic and policy change. Like the public health examples above, it calls for collaborating with other professionals and community members as equal problem-solvers, and for professionals to educate and also to be “educated by all those with whom they come in contact, particularly about the traditions and experiences of life on the bottom and at the margins.”³³

Although the example given above of the child with asthma illustrates the benefits of doctors and lawyers collaborating to improve children’s health, it represents a crisis legal intervention model, analogous to a crisis health care intervention, as would be provided in the emergency department rather than in a preventative setting. Experience practicing in this MLP framework with Micronesian populations informs this call for a rebellious approach. To be successful, MLP needs to connect with families where they are, when they are ready, and follow their lead in care and decision-making.

MLP practice should move from legal care (crisis intervention) to becoming a medical-legal home for vulnerable communities. Getting to an integrated medical-legal home requires adopting practices from rebellious lawyering—principally embracing collaborative problem-solving alongside community members—for patients and clients in a medical home setting.

Conclusion

Since its founding in 2009, the MLPC Hawai‘i model has evolved to become a medical-legal home while working with Chuukese communities in Kalihi Valley. But this evolution holds the promise of addressing health-harming legal needs for other COFA and Pacific Island populations, and vulnerable communities generally. As discussed above, building a medical-legal home together demands highly integrated services, and legal and policy work that is community-informed and frequently community-led, leaving the responsibility and power of systemic change in the hands of those most affected. The innovator of the community health centers (CHC) model, Jack Geiger, MD, stated that the CHC movement was rooted in “the civil rights movement of the 1960s, and its goal of a truly democratic and equitable society.”³⁶ A medical-legal home model is perhaps best suited to realize a public interest lawyering approach that moves us towards that equal society, where patient-clients are the drivers of community change, supported and backed by an interdisciplinary team of professionals.

Practical Implications

This paper highlights the work of one Medical-Legal Partnership program among a network of more than 300 MLP health sites in 46 US states. The medical and legal directors of the Medical-Legal Partnership for Children in Hawai‘i encourage similar collaborations between law and medical/health professionals, as well as other social services and community partners, to promote broader solutions for the social and legal needs of vulnerable patients and communities. Although the core MLP components of direct legal services, professional and community education, and policy work are significant and effective, all of this work must be done in partnership and with the input of those patients-

clients most affected. This is true whether addressing individual medical and legal needs or greater policy matters. As doctors and lawyers, we must partner with vulnerable populations in defining their challenges and obstacles, developing strategies, and promoting their self-advocacy skills. Ultimately, our work is to promote community health, power and autonomy, and the MLP model is one avenue to achieving this goal.

Conflict of Interest

None of the authors identify any conflict of interest.

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